GUIDELINES
FOR THE DEVELOPMENT
OF
VERMONT'S ADOLESCENT
TREATMENT SYSTEM

2/03

Table of Contents

Introduction

This document was created as a learning resource to provide guidance to state agency staff, service providers, advocates, and others, as they work to develop Vermont's adolescent substance abuse treatment system.

It describes the adolescents to be served, key components of the service system, and specific practices that are essential to the delivery of quality treatment. Although it addresses many areas, the document is not an exhaustive description of a model service system. Rather, it focuses on those issues and components that Vermont is in the process of developing at this time.

It is a work in progress and comments, suggestions, and specific edits are welcome. They may be addressed to:

Win Turner, PhD
Adolescent Services Development Consultant
108 Cherry St.
Burlington, Vt. 05401
802-863-7208
wturner@vdh.state.vt.us

Source Documents for These Guidelines

We want to acknowledge California's Department of Alcohol and Drug Programs for generously loaning their Youth Treatment Guidelines to use as an initial model. Special thanks to ADAP staff, Diane Smith MA., Peter Lee MA., Chestnut Health's Lighthouse Institute Staff, Michael Dennis Ph.D., CSAT staff Randy Muck & Jutta Butler, The Physician Leadership on National Drug Policy – Adolescent Substance Abuse, A Public Health Priority, Drug Strategies - Treating Teens , Alan Budney Ph.D., and Cathy Stanger Ph.D. for providing us with key sections and ideas for the newly created Vermont Youth Treatment Guidelines.

Additional text and edits were contributed by:

Win Turner, PhD LADC
Michael McAdoo MA
Neill Miner

I) GUIDING PRINCIPLES FOR YOUTH TREATMENT

We are in a *Renaissance Period* of Adolescent Substance Abuse Treatment Knowledge and Improvement. After a decade of focused adolescent treatment studies, the scientific community has repeatedly shown that "treatment is effective" and much less costly than incarceration or other punitive means of countering substance use. However, with increased knowledge comes increased responsibility, and thus we now understand that adolescent treatment must include many systems of care (health clinics, schools, courts, community resources etc.) and long-term connections with youth and families. Surprisingly, although we know better what to do, we still reach only one of ten youth in need of treatment (Michael Dennis, Presentation in Vermont, 2001).

We now know that substance dependence is chronic in nature and shares many features with other medical disorders in the areas of: heritability, etiology, pathophysiology and response to treatment (adherence, relapse, medication effects). Substance abuse and dependence among youth is a complex problem. It is generally the result of multiple factors, including: 1) a biological predisposition toward substance use or other problem behaviors; 2) psychological factors such as depression or traumatic victimization; and 3) social factors such as family, community, and peer relationships. Biopsychosocial factors should be considered in order to maximize the benefit youth will obtain from treatment. The biopsychosocial model integrated into these guidelines will help draw attention to the complexity of factors that lead to substance related disorders and aid in understanding and treating these disorders. Substance dependence produces significant changes in brain chemistry and function. A multitude of studies suggest that the critical warnings include: onset before the age of 15, daily or weekly use of at least one drug, and/or poly-drug use. Research demonstrates that youth who make it through the early teen years without use decrease the likelihood of obtaining the disorder by as much as four times McLellan, Lewis MD, JAMA, 2000, PLNDP).

Additional studies into the nature of protective and risk factors are illuminating the core of healthy and unhealthy development. Human service workers should always attempt to first elicit and support an adolescent's strength. One way to begin creating a strength based relationship involves discussion of the four areas illustrated in the Native American "circle of care". The circle includes: mastery, belonging, generosity, and independence areas thought to be essential in healthy development. By initially engaging youth around these areas of their own strengths, we can help to open up a dialogue, foster a trusting, nonjudgmental, and positive relationship. Research findings support the necessity of building an engaging and therapeutic alliance within the initial stages of treatment (in the first 2 sessions) in order to increase retention and even positive recovery outcomes. (Randy Muck, 2002-Vermont Substance Abuse Conference presentation from ATM findings).

In adolescent populations that face more risks, we know that co-occurring disorders are the norm. Up to 80% of the adolescents meeting criteria for a substance disorder also met criteria for another mental health or behavioral disorder (Dennis 2002, in presentation from CYT, ATM, PETS-A). The co-occurring disorders that are most typical include (in order of most prevalent): oppositional defiant disorder, conduct disorder, ADHD, generalized anxiety disorder, and major depressive disorder. These problems are particularly high among adolescents who have been the subject of repeated (and often on-going) physical, sexual and emotional abuse (Dennis, Stevens & Chaffin, in press). Other factors associated with both substance use and conduct disorder include: family conflict, poor parental monitoring, parental psychopathology, parental substance use, academic problems and associations with deviant peers. For youth diagnosed with both substance use and conduct disorders, research findings demonstrate that conduct problems predict the outset of substance use. (Alan Budney in presentation at the 2002 Vermont Substance Abuse Conference). Thus, it is not surprising that the majority of adolescent treatment referrals come from juvenile justice (44%) and then from the school system (22%), self/family (17%), and primary care (5%).

(Dennis et al., 2002, from 1998 Treatment Episode Data Set). In order to stop this alarming trajectory toward delinquency, we must retrain our caretakers in health settings and all other youth based environments to screen and pick up early signs of risk and substance use.

Currently, the best treatment models succeed in helping 30- 50% of adolescents achieve abstinence ninety days after treatment begins. This outcome rate remains consistent across a multitude of evidence based treatment studies (see findings from CSAT: Cannabis Youth Treatment (CYT) and Adolescent Treatment Model (ATM). The findings also demonstrate that as long as treatment is age appropriate, and based on psychologically "sound" theory i.e. utilizing behavioral, motivational, and/or family based strategies, outcomes generally remain similar regardless of the specific type of treatment, the modality (individual or group) and the length of treatment (5,12 or 20+ sessions) (again see outcomes from CYT, ATM). While 30-50% initially improve, two thirds of these newly abstinent youth will relapse within 6 months. While this level of improvement and relapse rate is comparable, if not better, than treatment for other chronic medical diseases, we are certain that we can do much better! Doing so, however, will require both more attention to the quality of our initial care, and a more sustained approach to recovery management across episodes of care that may occur over a period of years.

Recent positive findings concerning behavior parent training, continued care protocols, contingency management schedules, urine test/breathalyzer monitoring, replacement activities, and self help recovery groups are beginning to illicit the essential components of comprehensive care for youth. We are learning that we need to rethink our ideas of care and move away from models focused on the single discrete treatment episodes. Fifty to sixty percent of those abstinent after treatment will relapse in the first 30 days after discharge (Mark Godley, in presentation at SAMHSA). We now realize that additional components of treatment are critical and that the assertive continued care and recovery check-ups, are likely to be as important as the initial episode of treatment. This manual will attempt to act as a guide to the latest principles of treatment.

Top clinical researchers, practitioners and policy makers in the field (including: Dr. Dennis, Ms. Adams, Dr. Fishman, Mr. Fraser, Drs. Mark and Susan Godley, Dr. Turner and Mr. Muck) have developed recommendations for designing effective continuums of care. These recommendations are most effective when treatment programs are guided by a culture of learning and sound clinical management procedures. The procedures detailed below should include performance based monitoring strategies using service logs allowing quick access to track services across an entire caseload. Training should include an implementation phase to help support new clinical supervision strategies such as audio-taping therapy sessions for case review and feedback. There is also a need for a progressive set of evaluation tools that are GPRA, and HIPAA compliant and incorporate assessment for screening, clinical (e.g. biopsychosocial assessment, placement, and treatment planning), program evaluation (needs assessment, clustering, fidelity, outcomes and benefit cost purposes) follow-up, and collateral information.

Training in Vermont

Due to the increasing and changing knowledge in the field adolescent treatment, our treatment providers will need to continually become informed and re-educated. ADAP is fully committed to training treatment providers in the latest research based treatment skills. The training unit is currently offering many workshops with continuing education credits to help keep providers up to date.
Please log on to ADAP's website www.state.vt.us/adap - then click on the training tab for information.
If you have any questions, please call the Training Unit Chief.

Essential components of effective treatment include:

Assertive Outreach – activities to educate and link treatment programs to referral sources. Examples of networking and marketing strategies include: community forums, collaborative agreements, brochures with program descriptions, open houses, recovery month activities, and toll free help lines, ADAP is committed to assisting each treatment program develop working agreements with community referral agencies and disseminating program specific brochures.

Progressive Assessment – human service workers need an understanding of the stages of use, the areas of life that are affected by substances and how to assess when it becomes a problem. This guideline supports the use of several age appropriate screening and assessment tools included or cited in the appendix. In Vermont we have already implemented the CRAFFT and MAYSI-2 for brief and co-occurring screening tools. The Center for Substance Abuse Treatment (CSAT) is also encouraging adolescent and co-occurring disorder programs to use the Global Appraisal of Individual Needs which is GPRA and HIPAA compliant (GAIN I, GAIN Q, M90 for follow-up).

Availability of a Continuum of Care - there needs to be a continuum of care to respond to the full range of service needs. Currently, Vermont does not have a fully developed treatment system and we need to develop one with ample services statewide including: prevention, screening, assessment, intervention, a menu of treatment options, case management/specialized rehabilitation, and continued care.

Conducting Recovery Management Check Ups – this vital and often lacking component of treatment needs to be developed in Vermont. Due to the chronic nature of substance disorders one must check on the availability of the recovery environment and support; check on how old lapses are handled and develop plans with new approaches to proactively encourage re-intervention if needed. Programs are advised to meet the new federal standards for client follow-up at 3,6,9, and 12 months post discharge.

Providing Comprehensive Services – programs must take into account the individuality and co-occurring or co-existing mental health needs of adolescents with substance disorders. There is little evidence that one modality of treatment or session format (individual, group, & family) is appropriate for all clients thus flexibility, availability and treatment matching a client's needs to available services is therefore, the most effective approach. Programs need to emphasize the acquisition of new capacities rather than the restoration of old ones.

Adolescent Specific Treatment Services Need to Include:

- Targeted sessions (victimization, anger management, depression, gender, culture).
- Habilitative vs. rehabilitative
- Psychiatric services (further assessment, psychiatrist, medication management).
- Family programming (assessment, parent education, multi-family groups, family counseling, parent behavior training, home visits).
- Education services (on-site if residential).
- Wrap-around services (transportation, case management, coordination of care).
- Healthcare (contraception, sexually transmitted diseases, asthma/respiratory problems).
- Recreational activity (room for gross motor activities) and exposure to non-using activities.

Gender and Cultural Competence - Gender and cultural competence is essential in developing a successful therapeutic alliance between the teen and the counselor. Recent research points to significant differences between male and female adolescent drug users. "Gender responsiveness is creating an environment through site selection, staff selection, program development, content and material that reflects an understanding of the realities of women's lives, and is responsive to the issues of the participants" *(Stephanie Covington, Ph.D., Institute for Relational Development Center for Gender & Justice).* The same type of program responsiveness is critical for working with adolescents and families of mixed racial and cultural identities. Sensitivity to others and factors that help build trust are especially important for gay and lesbian adolescents who might not otherwise be willing or able to address key aspects of their identity. The current number of programs in Vermont that are gender and culturally responsive is increasing. ADAP is committed to assisting programs build awareness and develop the environmental/treatment components needed for inclusive care.

Comprehensive Engagement and Retention Strategies – most adolescents do not seek treatment and are referred by juvenile justice or schools, hence they often do not choose to stay involved in treatment. Thus, the notion that "less is more" is helpful in guiding the amount of "treatment sessions" delivered to youth. In addition, setting up special procedures to engage and retain adolescents is vital. These procedures include a thorough orientation and description of the treatment model, so that the youth and family knows what they can "expect" and what is "expected" of them. Contrary to common expectations, the median adolescent in VT is only receiving about 4 sessions of treatment over about 6 weeks (i.e., half get less). Thus we both need to make sure things get done early and to work on improving engagement/retention. Continuous monitoring of clinical services with service logs will allow assessment and revision to aid in increasing these vital services for youth.

Adolescent Focuses Treatment – services must be engaging (i.e.-dynamic and active, "meet them on their own turf" e.g. no adult models), clinically and developmentally appropriate, and strength based. ADAP is implementing the use of adolescent specific evidence based treatment manuals that were designed to incorporate many of these principles. Currently, several Vermont treatment centers are adopting CYT manual guided treatment protocols. These protocols were designed taking developmental factors into account including: adapting situations, triggers, and consequences for youth, using motivational philosophies to engage the mandated population, using concrete vs. abstract concepts, dealing with loss of control issues, supporting recovery environments, and supporting continued care.

Care Management/Coordination - A "care manager" needs to be identified at each treatment site to follow the youth throughout their treatment course and link the youth to the next level of treatment. The care manager helps to deliver the follow-up and continued care protocols after treatment episode discharge.

Training, Staff, Supervision, Protocol Quality Assurance and Other Systems Issues

Training needs to be revolutionized. Due to the increase of clinical knowledge, training must include more than an orientation to an information set. There needs to be an implementation phase and then follow-up support to guarantee transfer and appropriate use of the new knowledge and skills.

Staff need to be diverse in terms of experience, education level, personality, recovery experience and demographics. ADAP has specified a set of credentials needed to become certified to work with substance abuse clients of any age. It is suggested that counseling staff desiring to work with youth and families should receive a minimum of two years supervised training experience with that population.

Supervision and clinical management should become protocol driven, so all administrators and clinical staff understand and can easily access clinical information across clients and the types services delivered. Performance and client based monitoring procedures such as therapeutic alliance, treatment and follow-up logs are necessary tools to support this agenda. ADAP advises programs to continually monitor clinical services: setting engagement and retention goals and the acquisition/delivery of evidence based treatment.

Program Evaluation – All substance abuse programs should be engaged in a process of continual learning directly from clients, staff, academic/clinical research institutions, national agencies (CSAT,CSAP, NIDA), other affiliated nonprofits, stakeholders and the community at large. The theme "what gets measured gets done" should drive the system change. Programs should utilize clinical management strategies to monitor services for engagement, retention, and performance. While ADAP recognizes there are many obstacles to conducting follow-up with clients, CSAT is advising programs to use time periods of 3,6,9, and 12 months after intake. ADAP requires all contracted programs to enter data into the Substance Abuse Treatment Information System (SATIS). ADAP has examples of clinical management forms that allow for continuous evaluation of services. Programs are advised to set engagement and retention goals and the acquisition of specific clinical skill sets for evidence based treatment delivery (see Service Log, Treatment Transition Log, and Follow-up Log).

Vermont's Division of Alcohol and Drug Abuse Programs (ADAP) is actively engaged in working with the entire system of care to explore, develop and support the strengthening of these components of adolescent treatment.

II) THE PARTNERSHIP IN SYSTEM DEVELOPMENT, IMPLEMENTATION, MAINTENANCE AND EVALUATION

Developing, implementing, maintaining and evaluating a treatment system for adolescents is an ongoing partnership among many groups, including:

- adolescents and their families, as users of the service system
- service providers, as funded by ADAP, other public and private funders of services, and
- ADAP, as authorized by the legislature and the governor

It is the right and role of adolescents and their families, as an adjunct to their participation in treatment, to:

- provide ongoing feedback and advice to both private agencies and the state agency and its sources of funding concerning the priorities, policies, and key programmatic decisions made by these agencies concerning adolescent treatment services.

Individual families may or may not choose to exercise this right, depending on their own special needs and circumstances.

It is the role and responsibility of private treatment agencies, under contract with the state agency, to:

- provide high quality treatment services to adolescents and their families, consistent with established contracts
- conduct, in cooperation and coordination with the state agency, program evaluation activities which help improve the quality and effectiveness of the agency's services
- maintain a strong and independent corporate organization, which is able to develop and deliver services which are reflective of and responsive to the needs of the local community
- provide ongoing feedback and advice to the state agency and its sources of funding concerning the priorities, policies, and key programmatic decisions made by the state agency concerning adolescent treatment services

It is ADAP's role and responsibility to:

- create and continually update a comprehensive vision of the nature and components of the service system
- obtain and carefully manage the public funds required to support the system
- contract with private agencies to provide treatment services as required by Vermont's adolescents and their families
- -to help ensure that treatment is targeted at people with abuse & dependence, while early intervention is targeted at people with early and/or hazardous use that is below the clinical threshold of abuse or dependence
- establish and monitor contractor compliance with minimum standards, guidelines, and other expectations to ensure that purchased services are delivered as intended, and in an effective and efficient manner
- create and maintain a vibrant and effective system of public input into all its significant activities and policy deliberations, in order that its activities and decisions are as informed as possible, concerning the perspectives of its partners in the process.

III) TARGET POPULATION DESCRIBED

The target population for youth treatment is individuals ages 12 through 17 (inclusive).

A program may serve youth ages 18 through 21 and individuals younger than age 12 if:

1. The program documents clinical appropriateness individually for each client;

2. The program has a written protocol that addresses developmentally appropriate services for that age group;

3. The youth is otherwise eligible for services or funding.

4. Services provided are not in conflict with any current law or regulation.

Admission priority should be based on ASAM PPC-2 criteria, program design, client assessment, and clinical judgment.

IV) SERVICES DESCRIBED

A) Services Related to Engaging Youth

1) Screening

Youth are far less likely than adults to be referred to treatment by a parent, family member, or self. Therefore, it is important that professionals who work with youth be able to identify youth alcohol, tobacco and other drugs problems and refer these youth for further assessment and/or treatment. A high priority should be placed on identifying children with alcohol, tobacco and other drugs and Co-occurring problems within other public service systems, such as schools, child protective services, county mental health, prenatal alcohol, tobacco and other drugs programs and corrections or probation programs.

Substance use falls in a continuum from experimental, occasional, problem use, abuse to dependency. Youth that initially are "learning" what substances will do their mind state, might never progress to a stage of "seeking out" or "chasing the mood swing" drugs and alcohol produce. We know that when a youth progresses from experimenting or occasional use to problem use their world is impacted in many ways and they begin to negatively affect many of their environmental relationships. People begin to take notice, and the youth "light ups" on people's radar screens, but the communication of those "radar blips" often is not relayed or additive and thus goes undetected. ADAP endorses the use of two standardized screening tools that are described below. In addition, ADAP endorses an educational intervention tool which can act to help guide the initial motivational interview, as well as raise parental and community awareness concerning the problems associated with substance use.

a) Youth in at-risk environments should be screened, using a tool designed for adolescents, to uncover indicators of alcohol, tobacco and other drugs and related problems. Youth with possible alcohol, tobacco and other drugs problems as identified through the screening should be referred for a more comprehensive assessment for substance abuse or dependence.

b) The initial interview format tool is known as the youth "radar screener and substance use problem chart". These two tools were designed to illustrate the range of problems that are associated with increasing substance use across multiple domains: the youth (health, mood and image), peers (pro-social to delinquent), family (engaged to checked out), legal (none to delinquent) and school (none to truant-failing). These tools are not meant to substitute for the standardized tools (CRAFFT & MAYSI-2) described below but rather to assist in the information gathering. See appendix – screening tools.

c) The screening tools should be brief and simple enough that a wide range of professionals can administer it with minimal training.

<u>CRAFFT</u>
The briefest screening tools can still provide enough information to help determine those needing more assessment. ADAP has endorsed the use of the CRAFFT a six question tool developed and validated by Robert Knight MD.

The CRAFFT is an ideal tool in health care settings, such as a primary care physician's office where time is the number one priority. ADAP also suggests asking an additional two questions that are also known to be associated to higher risk.

CRAFFT Questions:

1. Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself (alone)?
4. Do you ever forget things you did while using alcohol or drugs?
5. Do your family members or friends ever tell you that you should cut down on your drinking/drug use?
6. Have you ever gotten into trouble while you were using alcohol or drugs?

Additional Questions

7. Do you use tobacco products (smoking cigarettes, chewing tobacco)?
8. Have you ever had problems related to school (in school or out of school suspensions, absences, missing classes, late for classes, failure, and discipline problems)?

Scoring Criteria

Any single yes response should be noted as reason for concern and a plan for follow-up in the future. Any two yes responses on items 1-6 signals a risk for substance abuse and warrants further evaluation. Any yes response on items 7 or 8 is associated with higher risk for substance use and also warrants concern and possible need for further evaluation. Knight, MD. J. R., et al., June, 1999.
Questions 7 & 8 taken from Schwartz and Wirtz reworded & added in April, 2000 by the Adolescent Screening & Assessment Committee to meet the needs of Vermont's system.

The CRAFFT was not intended to screen for co-occurring issues, but rather to use in healthcare type settings that often missed substance involvement. A general rule of thumb: if time permits a MAYSI-2 should be used because it will give more specific information on other mental health needs.

MAYSI-2

ADAP has endorsed the Massachusetts Youth Screening Instrument -second edition, (MAYSI-2) to identify youths with substance issues and potential mental, emotional, or behavioral problems. The MAYSI-2 is a ten minute, 52 item, age appropriate tool, which is easy to administer and score. It is also now available on CD ROM in an auditory administration version, that automatically scores and creates a data file.

The MAYSI-2 is most often used in settings like child welfare, juvenile detention, drug court, and schools. Currently, ADAP is responsible for training, disseminating the MAYSI-2 statewide and organizing data collection. The MAYSI-2 questions address the following areas:

- Alcohol-Drug Use 8 items
- Anger-Irritability 9 items
- Depressed-Anxious 9 items
- Somatic complaints 6 items
- Suicide ideation 5 items
- Thought disturbance 5 items
- Traumatic experiences 5 items

(Thomas Grisso Ph.D. and Richard Barnum M.D., University of Massachusetts Medical School, 2000. see appendix)

2) Initial and Continuing Assessment

Assessment is not a single event upon the youth's admission to the program, but an ongoing process to gain insight into a youth's unique abilities, strengths, and needs. Assessment must be comprehensive and multi-faceted, culturally sensitive, and done in context with the youth's overall development.

a) Programs must complete a comprehensive assessment on all youth with indications of possible alcohol, tobacco and other drugs-related problems (as a result of a brief screening), including those being admitted to treatment.

b) The assessment must identify whether the youth is in need of treatment, and if so, determine and document the level of severity and recommended placement option for treatment, as specified by ASAM-PPC2 criteria.

c) Programs are advised to use one of the assessment tools identified and summarized in the Appendix (this does not preclude programs from using other assessments as well to cover additional areas or for interagency purposes). The assessment must be performed by a licensed alcohol and drug abuse counselor.

Special Note:

CSAT and treatment programs across the U.S. are now using the Global Appraisal of Individual Needs (GAIN) as the primary co-occurring assessment instrument. ADAP is also committed to training treatment providers to use the Global Appraisal of Individual Needs as a tool that should be considered for comprehensive assessment. The GAIN provides differing versions allowing one to conduct specific interview types depending on the need. The GAIN is available in a Quick version, a Full version, and a M90-Follow-up version. This free tool is GRPRA & HIPAA compatible, provides diagnostic information across necessary domains, allows for personalized feedback report, and is fully supported by the staff at the Lighthouse Institute www.chestnut.org.

d) A comprehensive assessment needs to include objective use data. An “on site” or laboratory drug test can meet this criterion.

e) The assessment should include a health screening (including a medical health history and disease screening). If the health screening identifies an issue that warrants further evaluation, the program must provide or arrange for a physical examination. (Residential programs must comply with their licensing regulations regarding physical examinations and disease screening/testing.)

f) The program should conduct a developmental assessment to assist in determining appropriate treatment approaches and interventions. The developmental assessment should evaluate cognitive and developmental levels, social/emotional skills, communication skills, and self-help/independent living skills.

g) Due to the critical importance of victimization in successfully treating substance disorders, ADAP is advising all programs to assess past victimization, risk of future victimization, and a plan for dealing with it. The program should specifically assess and identify safety issues, such as risk of suicide; current, or history of, physical and/or sexual abuse; or perpetration of physical or sexual abuse on others. If the assessment indicates high risk of danger to the youth or others, an appropriate referral must be made immediately.

h) The comprehensive assessment should be completed within the 30 days of admission. Programs should attempt to gather as much information on intake, and keep updating as more information is obtained (it may take some time to build trust and rapport with the youth before he/she will reveal more detailed and honest information).

i) Comprehensive assessment needs to be responsive to the youth, not just the service providers. A youth friendly feedback report should be generated that emphasizes self reported problems of substance use and their own reasons for quitting. This personalized feedback report (PFR) can help motivate the youth become engaged into treatment.

j) All Comprehensive assessment tools must comply with new Health Insurance Portability and Accountability Act (HIPAA). The new security and privacy regulations will drastically affect the administrative support and management of clinical records. Special care must be taken to safe-guard client records and databases as they are identified, entered, stored and communicated by computerized or electronic data systems. (see appendix for HIPPA information and website)

In the Spring of 2000, ADAP organized an assessment committee made up of Vermont clinical stakeholders and asked them to review and identify a list of needed components and tools to gather the information. The appendix includes more detailed information on particular tools. However, it was the consensus of the assessment committee that the following list of essential components be adopted as a guideline.

<u>Essential Assessment Components</u>

- Biopsychosocial History
- Collateral Information
- Diagnostic Criteria (for substance use as well as co-occurring issues)
- Substance Use History Chart
- Substance Problem Index/Reasons for quitting
- ASAM Criteria - 6 Dimensions
- Urine Test
- Personalized Feedback Report Form

3) Diagnosis

a) As part of a comprehensive assessment the licensed counselor must determine whether the client meets the diagnostic criteria of a substance related disorder in DSM IV.

b) Except as provided in 3 and 4 below, all youth accepted for treatment in low intensive outpatient, intensive outpatient, and residential treatment must have met diagnostic criteria for a substance related disorder in the DSM IV. A youth determined to be in need of early intervention services as described in the ASAM placement criteria does not need a DSM IV diagnosis.

c) A youth whose alcohol, tobacco and other drugs use symptoms are severe, but who does not meet the diagnostic criteria may be admitted to outpatient for further evaluation.

d) If the presenting alcohol, tobacco and other drugs history is not adequate to substantiate a diagnosis, the program may use material submitted by collateral parties (family members, legal, guardians, etc.) that indicates a high degree of probability of such a diagnosis.

4) Placement

a) Programs need to refer to treatment paying careful attention to treatment matching and base decisions on clinical appropriateness. For a given degree of severity or functional impairment adolescents often require greater treatment intensity than adults due to the complexity of developmental and environmental issues.

b) Still, programs must make every effort to keep the youth in the least restrictive environment, unless moving them into a more restrictive program is the only way to protect themselves or others from harm, or if all potential less restrictive environments have proven ineffective.

c) Use the newly developed adolescent section contained in ASAM's Patient Placement Criteria -Second Edition (PPC-2R) for the Treatment of Substance Abuse Related Disorders as a guideline for determining treatment setting and service matching. All six dimensions should be reviewed to assist in determining the most appropriate level of treatment and support services. (Marc Fishman, M.D. author of adolescent ASAM section has also written a chapter that illustrates the specifics of adolescent treatment matching, see Principles of Addiction Medicine, in Press.)

<u>ASAM Levels of Care</u>
0.5 Early Intervention
I Outpatient Treatment
II Intensive Outpatient
II.1 Intensive Outpatient
II.5 Partial Hospitalization
III Residential/Intensive Inpatient Treatment
IV Medically Managed Intensive Inpatient Treatment

<u>ASAM Dimensions</u>
D1: Acute Intoxication and/or Withdrawal Potential
D2: Biomedical Conditions and Complications
D3: Emotional, Behavioral, or Cognitive Conditions and Complications
D4: Readiness to Change
D5: Relapse, Continued Use or Continued Problem Potential
D6: Recovery Environment

d) Take into consideration the youth's age; developmental stage; gender; culture; and behavioral, emotional, sexual or criminal problems, to ensure the most appropriate program placement.

Note: given the rural nature of Vermont and small number of prospective clients in parts of the state and the limited availability of the preferred services, youth may be placed in a more or less restrictive setting than desired. When these inevitable, practical considerations have impacted on placement decisions, this should be continually assessed and monitored with the client's feedback and progress on treatment goals as a primary concern. To do this, programs will need to continually monitor services and provide assertive on-going care to support any treatment gains that have already taken place.

B) Levels of Service and Treatment Settings

1) Levels of Service

Substance-related disorders among youth occur in varying degrees of severity. A youth's alcohol, tobacco and drug use can range from experimental with minimal consequences to problem use, abuse and dependence with continued severe consequences. The level and type of treatment provided needs to be matched with the youth's degree of substance related problems. The adolescent criteria in ASAM's Patient Placement Criteria for the Treatment of Substance Abuse Related Disorders should be used as a guideline for determining appropriate placement. Many youth will under report the problems related to their substance use. Collateral sources of information such as parents, court diversion staff or other mentors can be critical in determining the impact of substance use and the relation to the six ASAM dimensions.

Treatment responses to substance use falls within two primary settings: outpatient and residential treatment. Family involvement needs to occur as soon as possible. (see details below). Generally, outpatient treatment is less restrictive and less expensive than residential treatment. It allows youth to receive treatment in their own community where disruption to family, school, and healthy social activities can be minimized. For youth with more complex or serious problems relating to alcohol, tobacco and other drug use, residential treatment can provide a secure setting protected from the influences and stresses of the substance using community. It may help diffuse the emotional intensity of a family or personal crisis, allow staff and peers to have a greater impact on the habilitative process, and facilitate close observation of progress in treatment.

a) Early Intervention (ASAM Placement Level 0.5)

Early intervention (or secondary prevention) is an organized service that may be delivered in a wide variety of settings. It is usually a brief contact or series of contacts designed to explore and address problems or risk factors that appear to be related to substance use, and to assist the youth in recognizing the harmful consequences of his/her use. Youth ending their involvement with substance treatment after this level of care are determined to be in the lower range of the severity continuum (experimental), and should not meet the diagnosis for a substance abuse or dependence disorder.

b) Low Intensive Outpatient Treatment (ASAM Placement Level 1)

Low intensive outpatient treatment is usually the first treatment option for youth needing services (60-70% of clients based on national treatment episode data set). It is most appropriate for youth in the low to medium range of the severity continuum and are experiencing minimal withdrawal risk and no medical or biomedical conditions. These youth are generally in school and in home environments that are supportive to their recovery, or the youth have the skills to cope with less supportive home environments. These youth are

generally sent to treatment by an external motivating entity (juvenile justice, school, family) and need motivating and monitoring strategies to address their impairment in major life activities. Youth in the adolescent treatment models (ATM) study referred to this level of care, demonstrated low levels of substance dependence (13+ %), were 15-18 years old (45 + %), greater number of males (70 + %), high weekly drug use among peers (60+ %), low levels of weekly drug use in the home, most often had no prior treatment, some victimization, low levels of mental distress, and medium levels of criminal involvement.

ADAP endorses a clinical model for this population that is based on motivationally enhanced cognitive behavioral treatment. The MET/CBT model builds engagement by recognizing existing youth strengths and assets, and soliciting their reports of problems associated with use and reasons for quitting. Additionally, youth are empowered by knowledge and skill rehearsal activities that discuss assertiveness techniques, precursors to use, healthy replacement activities, support networks, problem solving techniques, relapse triggers, and high risk situations. Treatment goals are negotiated, progress reviewed and random urine tests are utilized. General outpatient services are provided with a maximum of eight hours of treatment per week. Average utilization of services is expected to be a minimum of two individual sessions, three group sessions, and family involvement.

c) Intensive Outpatient Treatment (ASAM Placement Level 2)

Intensive outpatient treatment is appropriate for youth who are in the high range on the alcohol, tobacco and other drugs problem severity continuum with a level of impairment in major life domains that has the potential to distract from recovery efforts. These youth have a high enough resistance to treatment to require a structured treatment setting, but not so high as to render outpatient treatment ineffective. These youth may or may not be in school and are generally in home environments that are not supportive of their recovery; however, with structure and support, the youth can cope with remaining in the home and community.

The recommended clinical model for effectively intervening and treating this population is usually in a school or community based program that extends the school day schedule to include a wide array of services aimed at preventing further deterioration of the level of functioning, reducing and eliminating alcohol, tobacco and other drugs use, and supporting the youth's integration of therapeutic gains into his or her daily behavior. The recommended level of service is a minimum of nine hours per week, with the average utilization expected to be three hours of treatment activities per day, three to four times per week.

d) Residential Treatment (ASAM Placement Level 3)

Residential treatment is suitable for youth using substances with increasing frequency and at risk of withdrawal syndrome, but without a need for intensive medical monitoring. These youth are experiencing difficulty in many areas of their lives and have often demonstrated an inability to control their alcohol, tobacco and other drugs use and change negative behaviors after participation in less intensive treatment. Their home environments are either dangerous (e.g., on going threats of victimization) and necessitate removal, or are not conducive to successful treatment (e.g., frequent use in the home), or there are logistical barriers to outpatient treatment (e.g., lack of access to psychiatric services). The youth involved in residential services in the ATM demonstrated the following characteristics: high levels of substance dependence (70+ %), were 15 to 18 years old (80+ %), greater number of males (65+ %), high weekly drug use among peers, significant level of drug use in homes (25+ %), often been victimized (70+ %), high levels of acute mental distress, and high levels of criminal involvement.

Programs providing residential treatment for youth must comply with all applicable laws and regulations regarding licensing. Residential programs should utilize research proven strategies for providing the most effective adolescent substance abuse treatment. Currently, a combination approach utilizing modified

therapeutic communities (TC), 12 Step facilitation, behavioral, family and motivational enhancement treatments have demonstrated the most effective outcomes.

Residential treatment should provide intensive motivating strategies in a structured treatment setting with staff monitoring 24 hours a day, seven days a week. A planned regimen of individual and group counseling is provided to the youth daily. In addition, it is clear that programs are most effective when there is a clear schedule for orientation, treatment, links to the community for transition and continued care phases of the recovery program. Youth do best with a full schedule of daily activities, behavioral levels plan, explicit and consistent rewards for improvement and consequences for inappropriate behaviors, frequent and random therapeutic drug testing and the development of a positive peer culture.

2) Treatment Settings (Distinguishing types of Residential Services-Brief Description)

a) Short Term Residential Services

Recommended for youth who have not found success in outpatient based services and need the added intensity and structure of a residential setting. The length of stay is generally one to two months. Programs with the most successful retention provide very concrete and clear expectations from the outset. Academics are provided in addition to family, individual and group sessions. Currently, the only authorized Vermont short term residential program is called Phoenix Academy at Mountain View and uses a modified therapeutic community (TC) model. In the adolescent treatment models study, the short term residential programs were very different. Three types were evaluated –cognitive behavioral/spiritual, a medical model that blended a therapeutic community approach, and a more family systems approach. The medical model used psychiatric services with peer community reinforcements, 12 step facilitation and immediate linkage to the outpatient facilities. The family systems based program utilized a milieu approach, separate housing for girls, specialized groups, and focused on community involvement. The cognitive/behavioral/spiritual approach utilized adventure based therapy groups.

b) Long Term Residential Services

Recommended for youth, who by behavior and family situations need consistent and formalized structure for periods of 3 months to 1 year or longer. Long-term residential programs should provide accredited academic curriculum. The treatment planning is designed to include clear and delineated treatment goals. Often these programs use an adolescent adapted therapeutic community model with three phases of treatment: orientation and stabilization up (1 month), primary treatment (2-12 months) and transition/re-entry (3 months – more as needed). Therapeutic community models make rigorous demands on each participant. It is expected that the youth will be fully involved in community life in terms of openness, earned authority, discussion of personal issues, and job functions, invested in a whole personal change of being, thinking and caring. The utilization of these services recognizes that it is crucial to continue care and follow-up back in the community. Residential programs are responsible for linking the youth before discharge to continued care to reinforce the behavior changes.

c) Dual Diagnosis Treatment Residential Services

Recommended when a substance related disorder is only one of several mental health/behavioral health diagnoses leading to residential treatment. These programs include a combination of ongoing psychiatric and psychological services including appropriate individual and group therapeutic interventions. A full range of assessment services are usually provided in a medical/clinical setting which is usually locked, as well as staff secure. Youth needing these services are usually undergoing acute mental health distress and

referred by crisis services due to self harming behaviors or other forms of risk/suicidal intent. Brattleboro Retreat is a Vermont residential program that meets this category of treatment.

d) Locked Long Term Care Facilities

Recommended for youth with significant behavioral difficulties, diagnosed emotional difficulties or disorders. In most cases these youth are court ordered with substance abuse as only one of the symptomologies. The length of stay is mandated, with a year round admission, usually involuntary in nature. These are facility secure as well as staff secure surroundings. A full range of academic curriculum, treatment services and an intensive family program is recommended. An extensive after care planning procedure is needed to include probation, case management, family and clinical components.

C) Treatment Services (Important Characteristics by Component)

1) Treatment Planning

a) Programs must develop an individual treatment plan for each youth, based on information collected in the comprehensive assessment.

b) The treatment plan must be developed in conjunction with the youth and involve the youth in recognizing and appreciating his/her unique strengths and assets as well as clarifying needs.

c) The treatment plan must address multiple problems experienced by the youth (including co-existing disorders, medical illness, legal issues), and the complementary services needed to deal with these problems.

d) The treatment plan must include goals with realistic objectives and timeframes for completing them that are mutually agreed upon by the program and the youth.

e) The initial treatment plan should be completed at least within 30 days of admission. Progress in treatment must be monitored regularly and treatment plans modified as needs arise or change during treatment, at various stages of the youth's development and recovery. Experts suggest treatment plans should be reviewed at least every 60 to 90 days.

A critical issue in developing treatment plans to avoid making them be more “to do” for the counselor. They should be the “adolescents” plan and focus on only 2 to 4 things that the adolescent should be working on during or between sessions. If the adolescent cannot explain the treatment plan, it has too much information in it. One alternative that often works well is to have a more detailed master treatment plan, but a simpler plan that is what is shared with the adolescent and the focus of treatment.

2) Gender specificity

a) Few substance abuse treatment modalities for adolescent females or culturally sensitive interests (i.e. lesbian/gay population) are reported as evidence or research based. Therefore, adult literature regarding gender differences is currently applied to adolescents. Violence and trauma, for example, need to be identified and evaluated. Client’s present with differing levels of readiness, complexity and appropriateness for treatment based on age, developmental and emotional history. Understanding risk factors for the female gender may not comply with the traditional substance abuse program standards. Different treatment modalities can represent different degrees of safety to the female adolescent. Consideration for her point of

entry into a program (through a primary care physician, school, mental health agency) may also drive the development of a gender specific treatment plan. Discrimination and stigma should be explored to influence retention and success in treatment.

b) *Covington suggests* that in a re-evaluation of an integrated community treatment plan, the system and programs should always consider the following:

- Gender
- Environment
- Relationships
- Services – SA, trauma, MH, medical (Bulimia, Hep C/ HIV, etc.)
- Economic & Social Status
- Community

c) Girls who drink and use drugs may also have serious mental health problems, which can involve a "double dose" of symptoms, including both internalized anxiety, depression and post-traumatic stress disorder as well as aggressive, disruptive behavior. Depression and trauma in girls usually precede drug use; many teenage girls say they use alcohol and other drugs to make them feel better. Program staff may also not be aware of how the interactions between males, boys and girls in group or a centralized environment can lead to obstacles in treatment such as shame and not feeling safe.

d) The program should consider the benefits of separating girls and boys during treatment services and activities. There is increasing evidence that separate treatment for girls is more effective in building their self-worth, self-reliance, and educational and vocational skills. Many of Vermont's co-ed programs now try to provide effective care to girls, and hire female counselors for individual and non co-ed group sessions. Program and treatment materials developed for girls and young women can help to guarantee staff awareness and gender specificity. (For more information see, programs from both the Adolescent Treatment Models (ATM) & Drug Strategies Guide titled, Treating Teens).

3) Therapeutic Alcohol and Drug Testing

a) The program should provide or arrange for alcohol and drug testing for all youth diagnosed with substance disorders. ADAP does not endorse any one type of drug or alcohol test over another. Programs must thoughtfully balance the clinical usefulness of the test with the cost, time, and accuracy of the results. Accuracy of results are affected by many variables including: time elapsed from last use, body composition of the person, type of substance used, type of test used (urine, hair, saliva, breath, skin patch, blood etc.), type of test technology used (gas-chromato-spectrophotometry vs. emit immunoassays). Due to the enormous variables that affect accuracy, clinicians should be careful in interpreting numbers describing the amount of use, even if those numbers are adjusted for body fluid content.

b) The process of drug testing is aimed at providing objective measures to support youth, clinicians, parents, and mentors in motivating and sustaining healthy behavior change. We want to "catch them being clean" and help youth regain credibility with friends and family. The urine test provides reassurance of abstinence. This goal is best accomplished with random, frequent, observed, drug testing over longer periods of time with explicit rewards and consequences for test results. Accuracy of both laboratory and on-site alcohol or drug tests is dependent on many factors including the type of test technology and how long it takes to get the sample processed and how it was stored in between.

c) All youth should receive a drug test at intake/assessment and then throughout treatment, as well as during continued care. The frequency of alcohol and drug testing should be determined individually for each youth based on clinical appropriateness, and should allow for rapid response to the possibility of relapse.

d) Alcohol and drug test results are helpful in assisting diagnosis, confirming clinical impressions, helping modify the youth's treatment plan, and for continuing care support. Clinical decisions should not be based solely on these results. It is particularly important to realize that common urine test technologies (e.g., EMIT, RIA, lab & on-site tests) have false positive rates of 2 to 12% relative to GC/MS. GC/MS is the gold standard and often used for legal or medical purposes, but is more expensive laboratory based test.

e) In addition, test results are utilized for outcome evaluation. Results are examined from baseline at intake to discharge, and then 3,6,12 months post treatment. Many evaluations are now looking at the proportion of positive urinalysis collected over the intervening period.

4) Treatment Models

ADAP is committed to implementing evidence based treatment throughout Vermont, and many providers are currently involved in adopting manualized age appropriate treatment strategies. ADAP endorses the use of research based models from the Cannabis Youth Treatment Study (CYT), and referencing the Adolescent Treatment Models Study (ATM). For information on ATM programs and recently published manuals read Adolescent Substance Abuse Treatment in the United States and go to www.chestnut.org. ADAP has specifically set up a training initiative to help programs adopt the CYT manual one. Future plans include the implementation of other evidence based practice including CYT manuals two and three. The manuals are free and information is available at the following websites: www.chestnut.org or www.samhsa.gov .

a) When admitted to treatment, each youth should be assigned a primary counselor and when needed a care manager to oversee the case management, engagement and community. The primary counselor is responsible for building the youth's emotional trust and safety, recognizing the youth's individual strengths and assets, and assisting him/her to achieve success appropriate for his/her developmental stage.

b) ADAP recommends that programs provide individual sessions that are clinically appropriate and specified in the treatment plan, as well as for the following:

- upon admission to treatment help orient the youth to treatment;
- to develop and revise treatment plans;
- as needed for youth who are uncomfortable with the group process or are unready to discuss specific issues in a group setting;
- for crisis intervention;
- for discharge planning.

c) Programs should provide group counseling sessions as clinically appropriate and as identified in the treatment plan.

5) Family Interventions and Support Systems

Research has found that effective treatment for youth involves the family. Parents can be essential in modeling, motivating and monitoring youth toward positive behavior change. The CYT manual three is titled Family Support Network (FSN) and provides a good outline of how to involve family members

through parent education groups and behavior parent training. Research findings often support the notion the family therapy can be especially important for those youth who are normally the most difficult to treat. Therefore, ADAP endorses models of treatment that include parents in all phases of their child's treatment. However, it makes no ethical or legal sense to insist on the involvement of estranged parents in decision-making regarding their child's treatment. Instead, the program should create new opportunities for youth to develop supportive relationships with appropriate adults who will remain involved in their lives, both during treatment and recovery, and beyond.

a) Programs must make efforts to:

i. engage and include the family in the youth's treatment as early as possible (as part of the intake and assessment process), if clinically appropriate and specified in the treatment plan.

ii. provide individual family counseling, multi-family groups, and parental education sessions as clinically appropriate and specified in the treatment plan.

b) The program should help the youth develop a support system to reinforce behavioral gains made during treatment and provide ongoing support to prevent relapse. If a youth has no identifiable family to act as their support system, or the family is unable or unwilling to be involved, the program should attempt to provide a supportive, long-term mentor with whom the youth is comfortable, to be that youth's family and support during treatment and recovery.

6) Educational and Vocational Activities

a) Programs must fully integrate the youth's educational program into the youth's clinical program by:

i) providing youth access to educational instruction while in treatment, in accordance with state law;

ii) working with the educational system to address the youth's school related problems;

iii) developing a plan to assist the youth to successfully transition back into the community educational system, if appropriate.

iv) being the youth's advocate and liaison with other systems, help the youth and family negotiate the various service systems, and coordinate referrals.

v) networking and communicating with other community agencies providing services to youth in the program (including schools, child welfare, juvenile engagement with these various other agencies/systems, which may include group case management meetings.

7) Medication Management

Programs must manage youth's prescription medication in accordance with all applicable laws (i.e., those governing school sites and residential alcohol, tobacco and other drugs treatment programs). For programs that are not otherwise regulated in this area, the program must have an established protocol for management of youth's prescription medications that includes the program's policy regarding documentation, storage, supervision, distribution, and administration.

8) Structured Recovery-Related Activities

Intensive outpatient and residential programs must provide or arrange for both therapeutic and diversionary recreation. Therapeutic activities include art therapy, journal writing, and self-help groups. Diversionary recreation activities include sports, games, and supervised outings.

9) Discharge Planning

a) Programs should assist youth develop a discharge and aftercare plan that includes a structured graduation ritual, ongoing support to help sustain recovery; plans for future or continued employment, employment training, or school; and housing arrangements and assisted independent living if needed.

b) Programs should use the adolescent patient discharge criteria contained in ASAM's Patient Placement Criteria for the Treatment of Substance Abuse Related Disorders when determining length of stay and discharge readiness.

c) Programs must complete a written summary for each youth discharged from treatment that contains client profile information consistent with standard data sets. The summary should document progress towards goals and measurable outcomes during treatment, and characterize the youth's long-term success or failure during treatment.

10) Continuing Care

Programs must provide or arrange for continuing care services to youth after the completion of formal treatment and whenever professional intervention is needed to prevent relapse and support the youth's transition into recovery. Continuing care services include regular follow-up contact with therapeutic drug testing (one time a month for 12-18 months), coordination of goals, identification of signs of relapse and a plan to respond to such signs, family involvement, linkages to other services as necessary, aftercare sessions, self-help and peer support groups. It is especially critical that these services be proactive and assertive in their delivery; youth can easily “slip through the cracks” when passive referrals are set up without follow through by care mangers.

D) Other Critical Service Characteristics

1) Developmental

a) Programs must integrate a youth developmental philosophy as the foundation of treatment approaches to help empower youth to identify their unique strengths and build developmental assets.

b) Treatment placement, services, and therapeutic approaches must be individualized to reflect each youth's gender; and chronological, emotional, and psychological age.

c) The program must address potential long-term deficits in developmental, psychological, and social growth to help youth make up for the developmental stages that have been compromised due to substance use.

2) Culture and Language

a) Programs that serve youth whose primary language is not English, including sign language, must have or make available as needed, skilled bilingual staff and/or interpreters.

b) Staff must be trained in specific cultural issues, traditions, and beliefs in order to provide the most appropriate treatment for youth within the community.

c) All print and audio-visual materials used for educational purposes must be culturally, linguistically, and literacy appropriate for the youth and families being served.

d) Staff should foster an environment of acceptance of different sexual preferences and be prepared to address issues of sexuality and sexual identity, including those of gay, lesbian, and bisexual youth.

E) Service Coordination and Collaboration and Links With Other Systems

1) Case Management Notes

Programs must provide or arrange for case management services for every youth in treatment.
The case manager must have training and skills in the following areas:

a) alcohol, tobacco and other drugs treatment, an understanding of addiction, and the intergenerational nature of alcohol, tobacco and other drugs abuse;

b) familiarity with community resources and other youth service systems (education, child welfare, juvenile justice, mental health, etc.);

c) physical and sexual abuse;

d) family dynamics;

e) legal issues (informed consent for minors, disclosure of confidential information, child abuse/neglect reporting requirements, and duty to-warn issues).

2) Outreach

a) Programs must provide or arrange for outreach services that identify alcohol, tobacco and other drugs abusing youth and encourage them to take advantage of treatment services.

b) Outreach efforts should target youth in at-risk environments.

c) High priority should be placed on linking with public systems already serving youth with alcohol, tobacco and other drugs problems, such as schools, child welfare, public health, mental health, and juvenile justice.

d) Outreach activities should also include educating professionals and policy makers in these systems so that they become referral sources for potential clients.

3) Critical Linkages

a) The program should develop strong linkages with existing health, mental health, social, educational, mentoring, and employment development programs that provide services to youth. This includes the alcohol, tobacco and other drugs services system as well, since alcohol, tobacco and other drugs prevention programs and prenatal treatment programs provide opportunities for identification and referral of youth with alcohol, tobacco and other drugs problems.

b) The program must collaborate with other agencies providing services to the youth to ensure a coordinated approach. These should include Student Assistance Programs, Developmental and Mental Health Services, Social Rehabilitation Services, Department of Employment and Training, Department of Education, PATH (social welfare) and other community based organizations providing services to youth.

c) When applicable, and in accordance with state and federal laws regarding disclosure of confidential information, the program should include representatives from these other agencies during case conferences and treatment planning.

V) PROGRAM EVALUATION AND OUTCOMES

A) System Level Outcomes:

The partners in the service system should evaluate for system level outcomes, including:

1) increases in youth-specific programs/treatment capacity;

2) increasing access to youth specific services;

3) increasing quality of services;

4) achieving and maintaining a continuum of care for youth. The Washington Circle group has identified a group of performance measures that are important in program evaluation and include: initiation, engagement, retention, and checkups/continuing care.

B) Client Specific Outcomes:

Programs should evaluate for client specific outcomes for youth in treatment, such as:

1) reduction and/or elimination of alcohol, tobacco and other drugs use; demonstrated by urine analysis at intake, discharge, and at 3, 6, & 12 months post treatment. For specifics on urine analysis refer to the section titled "Therapeutic Drug Testing" page 16.

2) improved level of functioning in major life domains; measured by the Global Assessment of Functioning (GAF) Scale, increased school attendance, decrease in delinquent activities, increase in pro-social activities including vocational training or employment and any additional pre/post evaluation instrument used as part of the initial assessment.

3) length of stay in each placement and evaluation of safe treatment in the most appropriate, least restrictive settings.

C) Periodic Client Evaluations:

Programs are responsible to perform follow-up evaluations of services at 3, 6, & 12 months post treatment. These evaluation interviews should be conducted in person and a drug test should be performed.

VII Client Protections

A) Safety Issues: Care and Supervision of Minors

1) The program must provide the level of structure, care, and supervision necessary to ensure the safety of youth at all times while on the program site. Appropriate care and supervision includes the maintenance of rules for the protection of youth; supervision of youth schedules and activities; monitoring of food intake/special diets (when meals or snacks are served); and storing, distribution, and assistance with taking medications [see (b) of this Section].

2) Programs must provide or arrange for educational sessions and culturally appropriate materials that address issues such as HIV/AIDS and other health matters (STDs, tuberculosis, hepatitis, nutrition), sexuality/family planning, violence prevention, independent living skills, and smoking cessation.

3) As appropriate, programs must provide or arrange for academic and work readiness skills, career planning, and job training for youth. The program must also develop and maintain collaborations with local vocational programs and the workforce investment board.

APPENDICES

1) Adolescent Specific Substance Abuse Screening & Assessment Tools

An ** symbolizes tools that are currently recommended for use by providers in Vermont.

Screening

Screening refers to a brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation. In a general population, screening for substance abuse and dependency would focus on determining the presence or absence of the disorder, whereas for a population already identified at risk, the screening process would be concerned with measuring the severity of the problem and determining need for a comprehensive assessment. Screening determines 'the need for a comprehensive assessment', it does not establish definitive information about diagnosis and possible treatment needs. The screening process should be brief - no longer than 30 minutes, preferably only 10-15 minutes. It should have applicability across diverse populations (SAMHSA., 1994).

A screen should be simple enough that a wide range of health professionals can administer it. It should focus-on the adolescent's substance use severity (primarily consumption patterns) and a core group of associated factors such as legal problems, mental health status, educational functioning, and living situation. It must have peer-reviewed published data on the reliability and validity of the measure. Ideally everyone in the area would use a single measure and adopt consistent referral criteria.

Listed below are the recommended screening and assessment instruments for use with youth.

Adolescent Screening Tools:

**** CRAFFT**

The CRAFFT is a validated six question user friendly adolescent specific substance abuse screening tool, designed to be the age appropriate alternative to the CAGE. Two or more yes answers suggests a significant problem. This tool was developed J. Knight MD, Center for Adolescent Substance Abuse Research, Children's Hospital Boston.

Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?

Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

Do you ever use alcohol or drugs while you are by yourself ALONE?

Do you ever FORGET things you did while using alcohol or drugs?

Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?

Have you ever gotten into TROUBLE while you were using alcohol or drugs?

In addition to the six questions above, ADAP endorses the use of two additional questions demonstrated to be associated with higher risk for substance abuse:

Do you SMOKE cigarettes, or use chewing tobacco?

Have you ever had problems related to SCHOOL (in school or out of school suspensions, absences, missing classes, late for classes, failure, and discipline problems)?

**** MAYSI-2**

The Massachusetts Youth Screening Instrument Second Version is a self-report inventory of 52 questions designed to identify youths 12-17 years of age who may have special mental health needs. It was originally intended for use at any entry or transitional placement point in the juvenile justice system. In Vermont, it has been accepted as a first level dual diagnosis screening tool to assist in early identification of multiple issues including substance abuse, trauma, suicide ideation, anger, anxiety and depression.

*** Drug and Alcohol Program (DAP) Quick Screen**

The DAP was developed as a rapid in-office test for adolescent substance use problems for use in primary care setting. It is a 30-item test with four critical questions; there are "red 'flags" for AOD abuse, depression, and suicide. The self-administered, paper-and-pencil questionnaire is hand-scored, but the scoring is simple. Responding "yes" on 6 or more items indicates need for comprehensive assessment. The questionnaire 'Takes about 10 minutes to complete. The questionnaire requires a 6th grade reading level. The DAP assesses substance use, relationships with parents, friends' and parents' use of AOD, participation in risky behaviors, conflict with parents, school misbehavior, and also contains questions on depression and suicide.

*** Juvenile Automated Substance Abuse Evaluation (JASAE)**

JASAE is a 108-item computer-assisted screening/assessment evaluation designed to measure alcohol and drug use/abuse juveniles ages 12 through 18. Based upon adolescent norms, this instrument addresses patterns of alcohol or drug use as well as attitudes and life circumstances related to such use. JASAE provides a suggested DSM-IV classification and a suggested referral based on American Society of Addiction Medicine guidelines. This evaluation requires a 5th grade reading level and takes 20 minutes to complete. JASAE is copyrighted and costs $4.50 per form. Published psychometric data are not available.

*** Personal Experience Screening Questionnaire**

This 40-item screening too evaluates the need for comprehensive drug use evaluation and provides information on psychosocial problems, drug use severity, drug use frequency and onset and faking tendencies. Internal consistency is excellent for the problem severity scale but has not been demonstrated for the other two scales of this instrument. Content validity is good for the problem severity scale and satisfactory for the other scales. The instrument demonstrates moderate -construct validity and excellent criterion validity. The test is at the 4th grade reading level and requires 10 minutes to complete. The PESQ is copyrighted and is priced as follows: $42.50 per manual and $25.20-$29.50 per package of 25 test forms.

*** Problem Oriented Screening Instrument for Teenagers**

POSIT is a 139-item self-administered questionnaire used to identify potential problem areas for teens, ages 12-19. Areas covered by this screen include substance use and abuse, physical health, mental health, family relations, peer relations, educational status, vocational status, social skills, leisure/recreation and aggressive behavior/delinquency. A follow-up questionnaire has been developed also. The test requires a 5th grade reading level and 'takes approximately 20-30 minutes to complete. Scoring takes 2 seconds by computer and 2-5 minutes when scored by hand. Very good psychometric properties, published in peer-reviewed journals.

*** Adolescent Substance Abuse Subtle Screening Inventory (SASSI)**

A self-administered "true/false" questionnaire for adolescents aged 12-18. Includes 6 scales (alcohol use, drug use, obvious attributes, subtle attributes, defensiveness, and correctional). Requires no training and the test is easy to score/ interpret. There are a total of 81 items, with 55."indirect" or subtle questions and 26 questions that are face valid, direct questions about AOD use. Requires 5th grade reading level. Peer-reviewed psychometric reports are not available.

Recommended Tool for Quicker Assessment:

**** GAIN-Q**:

Designed to identify those in need of referral for a more detailed assessment on substance use and/or mental health problems. Eight pages in length, interviewer- or self-administered in 15 to 20 minutes, most items written in “yes/no” format. Eight sections - Background, General Factors, Sources of Stress, Physical Health, Emotional Health, Behavioral Health, Substance-Related Issues. First four sections are background and formative indices of factors related to behavioral health problems, next three sections (Emotional Health, Behavioral Health, Substance-Related Issues) are core behavioral health indices and assess the breadth of problems using the core symptoms from the central scales of the full GAIN. “Reasons for Quitting”and “Problems associated with Use” modules to support brief interventions with substance users. Personalized feedback report, referral and recommendation summary report generated from information gathered. Computer applications are HIPAA compliant and allow items to be imported electronically into the full GAIN if needed.

Internal Behavior Index (IBI)
- Depression Symptom Index (DSI-5)
- Suicide Risk Index (SRI-3)
- Anxiety Symptom Index (ASI-7)

External Behavior Index (EBI)
- Attention Deficit/Hyperactivity Disorder Index (ADHDI-6)
- Conduct Disorder/Aggression Index (CDAI-6)
- General Crime Index (GCI-4)

Substance Problems Index (SPI)
- Substance Use & Abuse Index (SUAI-9)
- Substance Dependence Index (SDI-7)

Comprehensive Assessment

Comprehensive assessment follows a positive screening for a substance use disorder and may lead to long-term intervention efforts such as treatment. The comprehensive assessment confirms the presence of a problem and helps illuminate other problems connected with the adolescent's substance use disorder. Comprehensive information can be used to develop an appropriate set of interventions. As one part of a larger assessment, a standardized measure to include in the comprehensive assessment should meet several objectives

1) To document in more detail the presence, nature, and complexity of substance use reported during a screening, including whether the adolescent meets diagnostic criteria for abuse or dependence.

2) To determine the specific treatment needs of the client if substance abuse or substance dependence is confirmed, so that limited resources are not misdirected

3) To ensure that related problems not flagged in the screening process (e.g., problems in medical status, psychological status, social functioning, family relations, educational performance, delinquent behavior) are identified

The assessor should be a well-trained professional experienced with adolescent substance use issues. The assessor should have sufficient training in psychological assessment, use of standardized measures, developmental psychology, and substance use disorders. The assessor should also be familiar with the local slang terms for particular drugs. The skill level of the assessor should be appropriate to the tasks required by the assessment process and the particular training needed to use the specific instruments.

There are a number of important domains that should be included in any comprehensive assessment. Ideally, these domains could be addressed in the standardized assessment that would allow for ready comparison to other published norms -and to evaluate the severity of a particular adolescent's problems. Some of the domains that are most relevant for this population include:

History of use of substances, including over-the-counter and prescription drugs, tobacco, and inhalants--the history notes age of first use- frequency, length, and pattern of use; mode of ingestion; treatment history-, and signs and symptoms of substance use disorders-,

Medical health history and current status;

Mental health history and current status, with a focus on depression, suicidal ideation or attempts, as well as details about prior evaluation and treatment for mental health problems.

Family history of substance use, mental and physical health problems and treatment, the family's ethnic and socioeconomic background and degree of acculturation, and a description of the home environment School history, including academic and behavioral performance, and attendance problems

Vocational history, including paid and volunteer work

Peer relationships, interpersonal skills, gang involvement

Juvenile justice involvement and delinquency-,

Social service agency program involvement, child well-are agency involvement (number and duration of foster home placements), and residential treatment

Leisure-time activities, including recreational activities, hobbies, and interests

****Global Appraisal of Individual Needs (GAIN)**

The GAIN is actually a series of standardized instruments designed to integrate the assessment for both clinical (e.g., diagnosis, bio-psycho-social assessment, placement, and treatment planning) and program evaluation (needs assessment, clustering, fidelity, outcomes, and benefit cost) purposes. Clinician, interviewer, computer or self administered assessment taking 60-90 minutes for low to moderate severity, up to 120 minutes for high severity clients. Software available for data entry, re-keying, scoring, computer assisted interviewing, and generating individual clinical (interpretive) profiles. Instrument and software modularized so that subsets of scales can be used and/or items added. Instruments, software, scoring syntax and norms available by age and level of care on the internet as a service to the public and available for a nominal ($1) license fee for use by others. Incorporates CSAT's GPRA reporting requirements and is HIPPA compliant.

Administration - including records information, cognitive impairment, calendaring, referral information, general instructions.

Background and Treatment Arrangements - demographics, custody, access to care.

Substance Use - including treatment readiness, relapse potential, withdrawal, abuse, and dependence, treatment history, content and satisfaction with recent treatment, current medication.

Physical Health - including disabilities, current and childhood infectious diseases, allergies, lifetime history, treatment history, current medication.

Risk Behaviors and Disease Prevention - including needle and sexual risk behaviors, sexual preference, birth control, tobacco use/dependence, fasting and exercise, testing and prevention classes.

Mental Health and Emotions - including somatic, depressive, suicide risk, anxiety, traumatic distress, ADHD, CD, personality disorder, treatment history, current medication.

Environment and Living Situation - including housing, homelessness, public/emergency housing, use in home, controlled environment, children status, living, vocational, and social risk, violence towards others, traumatic victimization, other psycho-social stressors, general social support, spirituality, general satisfaction.

Legal (Civil & Criminal) - civil court involvement, illegal activities, status offenses, arrest history, current criminal justice involvement, outstanding warrants and payments.

Vocational (School, Work, Financial) - educational attainment/degrees, school problems and involvement, military history, vocational attainment, work problems and involvement, current vocational status, financial problems, pathological gambling, TANF participation, personal and family income, HHS poverty index, drug/alcohol expenses.

End - administrative time, comments, signatures, administrative ratings and methods information, diagnostic impressions, special study information.

*** Adolescent Addiction Severity Index (ASI) Questionnaire**

The A-ASI is 2 286-item structured interview modeled after the adult version of the ASI. Like the adult version, the A-ASI measures client functioning in a number of domains- psychological, medical, legal, family/social, and employment. However, unlike the adult ASI, the A-ASI also measures current status in school. A JCAHO supplement allows for detailing the adolescent's typical day and includes a relapse triggers inventory. A subset of the A-ASI items are designed to serve as questions for a follow-up assessment. Based on our review, there is no scoring software for this assessment. Psychometric data were unavailable.

*** Comprehensive Addiction Severity Index- Adolescent (CASI-A)**

CASI-A is a semi-structured clinical interview that provides 2 comprehensive, in-depth assessment of the severity of an adolescent's AOD abuse in seven areas. It is designed to assist in the treatment planning for adolescents and to measure post-treatment outcomes. The instrument covers seven areas of functioning pertinent to adolescent alcohol or drug use, education status, substance use, use of free time, legal status, peer relationships, family relationships and psychiatric status. The interview takes 45 to 90 minutes to complete, depending on the adolescent's substance use history. Preliminary psychometric data indicate this instrument has good internal consistency and high concurrent validity. CASI-A is copyrighted.

*** Teen Addiction Severity Index (T-ASI)**

The T-ASI is a brief structured interview modeled after the ASI. This 134-itern interview provides basic information on an adolescent (ages 12-18) prior to treatment entry. The interview takes 30-45 minutes to complete. Scales: AOD use, school, employment/ support, family relationships, legal, peer-social relationships, psychiatric. status. Good inter-rater reliability but no other psychometrics published in 1994. No computer version available at this time.

*** Adolescent Diagnostic Interview (ADI)**

Structured interview which covers DSM criteria for abuse/ dependence (and also assumes that the DSM criteria developed for adults is applicable to adolescents). The interview covers AOD use history, signs of abuse/ dependence, level of functioning and psychosocial stressors. To some degree, it covers peer relationships, school/ home behavior, and screens for co-occurring mental/ behavioral problems. Takes 30-90 minutes to administer. This tool bears no relationship to the ASI. To date, only limited reports regarding psychometrics of the ADI.

*** Adolescent Drug Abuse Diagnosis (ADAD)**

ADAD is a 150-itern structured interview covering nine problem areas experienced by the adolescent: medical, school, employment, social relations, family and background relationships, psychological issues, legal issues, alcohol and drug use. The interview produces severity ratings for each area as well as composite scores on 83 items measuring behavioral change in each area at treatment baseline and discharge. The ADAD requires 45-60 minutes to administer and Can be used for diagnosis, treatment planning, and research. Inter-rater and test-retest reliability for this instrument ranges from good to excellent for the nine problem areas. Concurrent validity with other validated instruments is low for the medical and social relations Scales but moderate for the other seven scales. A computerized version is available.

*** Adolescent Problem Severity Index (APSI)**

APSI is a 45-60 minute structured screening interview based on seven screening areas: legal, family relationships, educational/work, medical, psycho/social adjustment, drug/alcohol use and personal relationships. The questionnaire has been designed to help professionals identify and respond to issues that may require intervention. Scoring includes composite scores of each problem area and ratings of the need for treatment. A computerized version is available. APSI is copyrighted. Psychometric data were unavailable.

*** DSM IV Criteria Based Interview**

This set of questions uses the DSM IV diagnostic criteria for specific disorders. Clinicians can choose among all syndromes but should use the following which are over represented in the adolescent population: ADHD (all types), ODD, Conduct Disorder, Substance Abuse and Dependence, Major Depressive Disorder, Generalized Anxiety and any others that are suspected to be of concern.